

**Drug Courts
Are Not the
Answer:**

**Toward a
Health-Centered
Approach
to Drug Use**

**A Drug
Policy
Alliance
release.**

**We are the Drug Policy Alliance
and we envision new drug policies
grounded in science, compassion,
health and human rights.**

Please join us.

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Executive Summary

This report seeks to address the lack of critical analysis that stymies the policy discussion on drug courts, to foster a more informed public debate on the 20-year-old criminal justice phenomenon, and to encourage policymakers to promote drug policies based not on popularity but on science, compassion, health and human rights.

This report attempts to answer two questions: 1) What impact have drug courts had on the problem they were created to address: the deluge of petty drug arrests that began to overwhelm courts and fill jails and prisons in the 1980s?; and 2) How do drug courts compare with other policy approaches to drug use in terms of reducing drug arrests, incarceration and costs as well as problematic drug use?

To answer these questions, the Drug Policy Alliance analyzed the research on drug courts, other criminal justice programs and non-criminal justice responses to drug use. We also received input from academics and experts across the U.S. and abroad. This comprehensive review of the evidence reveals the following:

- **Drug courts have not demonstrated cost savings, reduced incarceration, or improved public safety.**

Oft-repeated claims to the contrary are revealed to be anecdotal or otherwise unreliable. Evaluations are commonly conducted by the creators of the programs being evaluated, and the result is research that is unscientific, poorly designed, and cannot be accurately described as evidence.

Drug courts often “cherry pick” people expected to do well. Many people end up in a drug court because of a petty drug law violation, including marijuana. As a result, drug courts do not typically divert people from lengthy prison terms. The widespread use of incarceration – for failing a drug test, missing an appointment, or being a “knucklehead” – means that some drug court participants end up incarcerated for *more time* than if they had been conventionally sentenced in the first place. And, given that many drug courts focus on low-level offenses, even positive results for individual participants translate into little public safety benefit to the community. Treatment in the community, whether voluntary or probation-supervised, often produces better results.

- **Drug courts leave many people worse off for trying.**

Drug court success stories are real and deserve to be celebrated. However, drug courts also leave many people worse off than if they had received drug treatment outside

the criminal justice system, had been left alone, or even been conventionally sentenced. The successes represent only some of those who pass through drug courts and only a tiny fraction of people arrested.

Not only will some drug court participants spend more days in jail *while in drug court* than if they had been conventionally sentenced, but participants deemed “failures” may actually face longer sentences than those who did not enter drug court in the first place (often because they lost the opportunity to plead to a lesser charge). With drug courts reporting completion rates ranging from 30 to 70 percent, the number of participants affected is significant. Even those not in drug court may be negatively affected by them, since drug courts have been associated with increased arrests and incarceration in some cases.

- **Drug courts have made the criminal justice system more punitive toward addiction – not less.** Drug courts have adopted the disease model of addiction but continue to penalize relapse with incarceration and ultimately to eject from the program those who are not able to abstain from drug use for a period of time deemed sufficient by the judge. Unlike health-centered programs, drug courts treat as secondary all other measures of improved health and stability, including reduced drug use and maintenance of relationships and employment.

Some people with serious drug problems respond to treatment in the drug court context; not the majority. The participants who stand the best chance of succeeding in drug courts are those without a drug problem, while those struggling with compulsive drug use are more likely to end up incarcerated. Participants with drug problems are also disadvantaged by inadequate treatment options. Drug courts typically allow insufficiently trained program staff to make treatment decisions and offer limited availability to quality and culturally appropriate treatment.

Based on these findings, the Drug Policy Alliance recommends better aligning drug policies with evidence and with public health principles by:

- Reserving drug courts for cases involving offenses against person or property that are linked to a drug use disorder, while improving drug court practices and providing other options for people convicted of drug law violations;
- Working toward removing criminal penalties for drug use to address the problem of mass drug arrests and incarceration; and
- Bolstering public health systems, including harm reduction and treatment programs, to more effectively and cost-effectively address problematic drug use.

Introduction

Most drug courts have done a poor job of addressing participants' health needs according to health principles, and have not significantly reduced participants' chances of incarceration. They have also absorbed scarce resources that could have been better spent to treat and supervise those with more serious offenses or to bolster demonstrated health approaches, such as community-based treatment.

Forty years after the United States embarked on a war on drugs, national surveys reveal that a large majority of Americans now believe that drug use is a health issue.¹ This social development has manifested in significant policy change. Several states have passed legislation requiring public and private health insurers to cover drug and mental health treatment on par with treatment for other chronic health conditions. On the federal level, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and the even more expansive Affordable Care Act of 2010 promise to make drug treatment much more accessible within the mainstream health care system.

Nevertheless, U.S. policy remains dominated by a punitive approach to drug use. This legacy of punishment – and its inherent conflict with a health-centered approach – has persisted throughout the 20-year-old drug court experiment.

There is no doubt that drug courts – programs that seek to reduce drug use through mandated treatment and close judicial oversight – were created and continue to be run with unflagging dedication and concern for the health and wellbeing of individuals and communities. Nor is there any doubt that drug court judges and their staffs have helped change, even save, many lives. Most drug court judges have felt deep satisfaction in being able to help participants overcome chaos, illness and despair. There is, indeed, no shortage of success stories. Many participants have had dramatic, life-altering experiences in drug courts. Criminal justice sanctions do indeed deter some people from using drugs, and some people will stop their drug use when faced with the threat of such sanctions. These observations, however, do not end the discussion.

Most interventions help at least some people, and drug courts are no exception. But it is important to consider the full range of drug court impacts, both positive and negative, on all participants as well as on the criminal justice and other systems. It is also important to consider drug court outcomes within the larger context of potential policy options and practices to reduce drug arrests, incarceration and problematic drug use. In this light, the benefits of drug courts pale considerably.

The issue is not whether drug courts do some good – they undoubtedly do – but whether the proliferation of drug courts is good social policy as compared with other available approaches to addressing drug use. This report finds that, based on the evidence, drug courts as presently constituted

provide few, if any, benefits over the incarceration model on which they seek to improve. Alternatives to incarceration for drug possession remain essential, but better alternatives must be adopted and incarceration for drug law violations should be reduced through sentencing reform.

Sitting squarely within a framework of drug prohibition,² most drug courts have done a poor job of addressing participants' health needs according to health principles, and have not significantly reduced participants' chances of incarceration. They have also absorbed scarce resources that could have been better spent to treat and supervise those with more serious offenses or to bolster demonstrated health approaches, such as community-based treatment.

Most drug courts have limited their own potential to improve public safety by focusing largely on people who use drugs but have little, if any, history of more serious offenses. Many people end up in drug court because of a drug law violation – many appear to be for marijuana.³ (The National Drug Court Institute found marijuana to be the most prevalent drug of choice among participants in at least 25 percent of drug courts surveyed nationwide in 2007.⁴) In fact, a 2008 survey of drug courts found that roughly 88 percent exclude people with any history of violent offending, and half exclude those on probation or parole or with another open criminal case.⁵ Moreover, about one-third of drug court participants do not have a clinically significant substance use disorder.⁶ The same survey found that 49 percent of drug courts actually exclude people with prior treatment history and almost 69 percent exclude those with both a drug and a mental health condition.

This report examines drug courts in light of the criminal justice and health issues they were designed to address. It takes as a premise that punishing people who have neither done harm to others, nor posed significant risk of doing harm (such as by driving under the influence), is inappropriate, ineffective and harmful to individuals, families and communities. The report also recognizes that, whether the chronic health issue in question is hypertension, diabetes or drug use, punishing people for straying from their treatment plans, falling short of treatment goals, or relapsing, is contrary to core health principles.

The central thesis of this report is that there is an urgent need for a non-criminal, health-centered approach to drug use. This approach must be founded on the understanding – as evidence consistently demonstrates – that the benefits of punishment-oriented treatment programs for most people

whose illegal activity is limited to petty drug possession are outweighed by the negative consequences. These negative consequences include the lost opportunities of failing to dedicate criminal justice resources to more significant public safety matters and of failing to pursue effective, health-oriented policy interventions in response to drug use.

A health-centered approach would ensure that drug use or the perceived need for treatment should *never be the reason* that people enter the criminal justice system, and that the criminal justice system should *never be the primary path* for people to receive such help. Individuals' drug problems can be addressed, families and communities preserved, public health and safety improved, and money saved by providing assistance to people not only after but *before* drug use becomes problematic, *before* families fall apart, *before* disease spreads, *before* crimes are committed and *before* drug use becomes fatal.

While there is no basis in principle or evidence-based policy for bringing people into the criminal justice system (whether to jail or drug courts) solely for a drug possession offense, drug courts may be appropriate for people who have committed other offenses that require accountability, restitution and possibly incarceration. With this in mind, this report includes several relevant findings and recommendations.

The *Drug Courts and the Drug War* section of this report describes the evolution of drug courts and puts them in the context of current drug arrest practices and sentencing policies.

The next section, *Understanding Drug Courts: What the Research Shows*, provides a careful review of drug court research. It finds that claims about drug court efficacy are methodologically suspect, that the impact on incarceration is often negligible, and that costs are underestimated.

Mixing Treatment and Punishment: A Faulty Approach explores how combining principles of treatment and punishment distorts the delivery of effective legal and health services; how this distortion further enmeshes people in the criminal justice system for their drug use; and how punishment will always dominate in this arrangement.

The *Toward a Health-Centered Approach to Drug Use* section presents a framework for reducing the role of the criminal justice system in what is fundamentally a health issue and for expanding effective approaches that minimize the harms of drug use. It also includes recommendations for improving drug court practices by, among other things, focusing them away from people facing petty drug charges.

Drug Courts and the Drug War

Drug courts emerged as a direct response to the rapid escalation of the war on drugs in the 1980s and 1990s. The era saw bipartisan support for stepped-up enforcement of low-level drug laws and enhanced criminal penalties for the possession and sale of small amounts of illicit substances.⁷ In turn, millions of petty cases flooded the court system and people charged with minor drug law violations received harsh sentences that drastically increased the number of people in jails and prisons.

Judges in courtrooms across the country became frustrated as the same individuals repeatedly appeared in court on petty drug charges or faced lengthy prison sentences for minor drug violations. Out of this frustration grew multiple efforts to turn the criminal courtroom into a site for therapeutic intervention, where judges aimed to reduce drug use through court-based interventions and court-supervised treatment.⁸

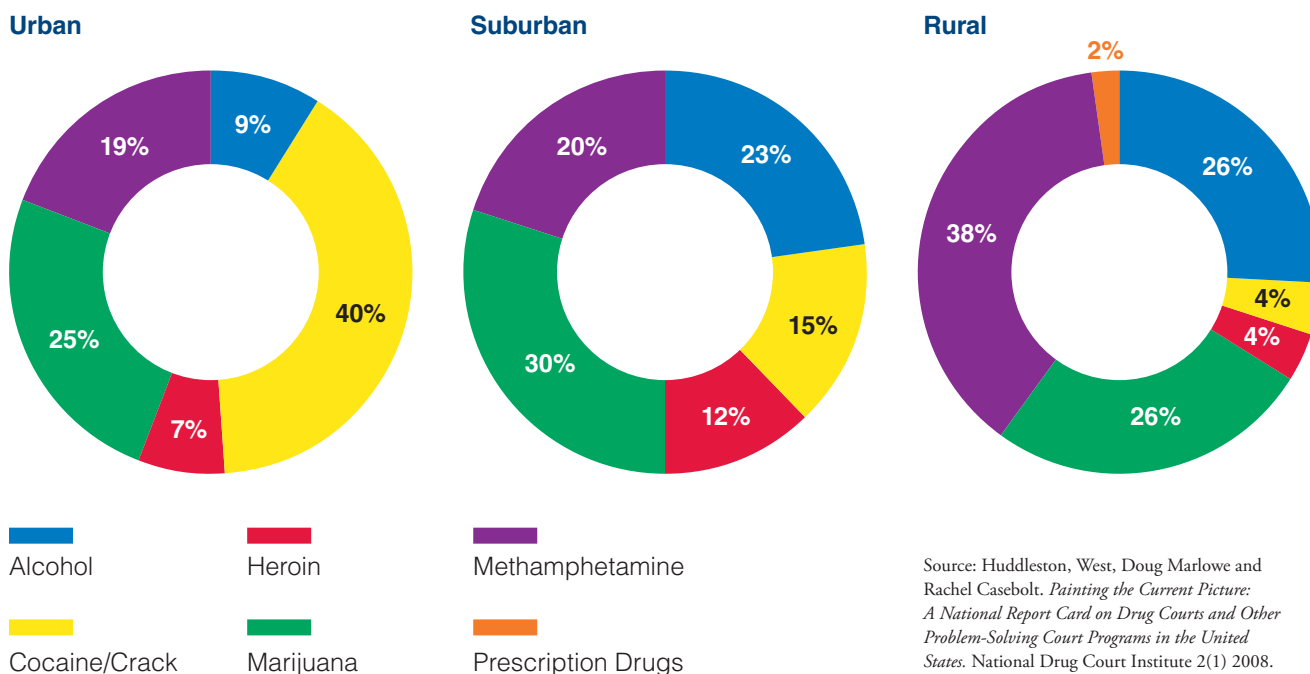
Drug courts are an application of therapeutic jurisprudence theories in which the judge does not ask whether the state has proven that a crime has been committed but instead whether the court can help to heal a perceived pathology.⁹ Drug courts adopted the disease model¹⁰ that posits that people struggling with drugs have a chronic disease that reduces their ability to control their behavior.¹¹

Because drug courts are developed locally, they tend to vary significantly in their rules and structure. (Indeed, drug courts are better understood as a category of approaches rather than a single type.) Typically, however, drug court eligibility is limited to people arrested on a petty drug law violation or property offense.¹² As noted previously, many of these appear to be marijuana violations. The prosecutor exercises wide discretion in determining who is actually referred to drug court. (Even where eligibility is met, about half of drug courts report rejecting eligible individuals because of capacity reasons.¹³) In most cases, participants must plead guilty as a prerequisite to entrance. Upon pleading guilty, they are mandated to treatment or other social service programs. Abstinence is monitored through frequent drug testing. Positive drug tests and other program violations are punished with sanctions, including incarceration and removal from the program.

In drug court, the traditional functions and adversarial nature of the U.S. justice system are profoundly altered. The judge – rather than lawyers – drives court processes and serves not as a neutral facilitator but as the leader of a “treatment team”¹⁴ that generally consists of the judge, prosecutor, defense attorney, probation officer and drug treatment personnel. The judge is the ultimate arbiter of treatment and punishment decisions and holds a range of discretion unprecedented in

Primary Drug of Choice Among Drug Court Participants

Percentage of Surveyed Drug Courts that Ranked Each Drug as the Leading Drug of Choice Among Participants



Today, nearly 6 in 10 people in a state prison for drug law violations have no history of violence or high-level drug sales.

the courtroom,¹⁵ including the type of treatment mandated, whether methadone prescription is acceptable (and at what dosage) and how to address relapse. The defense lawyer, no longer an advocate for the participant's rights, assists the participant to comply with court rules.¹⁶

The expansion of drug courts and other criminal justice programs that mandate treatment in the community (as opposed to behind bars) over the last twenty years reflects a growing sentiment that incarceration is not an appropriate, effective or cost-effective response to drug use. At first glance, their expansion might suggest that U.S. policies toward drug use have become more compassionate and health-oriented; yet the dominant policy response to drug use in the U.S. remains one of criminalization and punishment.¹⁷

From both an international and an historical perspective, current U.S. drug laws are abnormally severe. Following President Reagan's call for a major escalation of the war on drugs in 1982, annual drug arrests tripled to more than 1.8 million in 2007¹⁸ (before declining to 1.6 million in 2009¹⁹). This increase primarily involved not serious drug trafficking or sales, but possession; 79 percent of the growth in drug arrests during the 1990s was for marijuana possession alone.²⁰ The number of people incarcerated for drug law violations has increased 1,100 percent since 1980.²¹ Today, nearly 6 in 10 people in a state prison for drug law violations have no history of violence or high-level drug sales.²²

The U.S. locks up hundreds of thousands of people annually for drug law violations that would not warrant imprisonment in many European and Latin American countries, where incarceration for drug possession alone is comparatively rare.²³ Even for drug law violations that warrant imprisonment in Europe, sentences are generally longer in the U.S.²⁴ For example, a large-scale trafficking offense in Sweden (considered to be one of the strictest European countries with respect to drugs) merits a *maximum* prison sentence of 10 years.²⁵ In the U.S., by comparison, for over two decades until 2010, distribution of just 50 grams of crack cocaine (the weight of one candy bar) triggered a federal mandatory *minimum* prison sentence of 10 years.²⁶ Even after the 2010 federal crack sentencing reform, distribution of just 28 grams of crack cocaine triggers a mandatory minimum sentence of 5 years.²⁷

In the U.S., the consequences of a criminal conviction, particularly for a drug law violation, are severe and life-long. People convicted of a felony, whether or not they are ever incarcerated, face significantly diminished employment opportunities and much lower lifetime earnings. They may be prevented from voting and/or prohibited from accessing student loans, food stamps or other public assistance.

Criminal justice policies have not only limited the freedoms and opportunities of people convicted of low-level drug violations, but have also determined *who gains access* to limited publicly funded treatment resources.

The country's treatment system has not expanded proportionately to meet the growth in criminal justice referrals to treatment, which accounted for about 38 percent of participants in publicly funded treatment programs by 2007 – including 162,000 people ordered to treatment for marijuana that year.²⁸ As a result, treatment access for people seeking treatment voluntarily outside of the criminal justice system has diminished.²⁹ The proportion of treatment capacity available to the hundreds of thousands of people who seek treatment voluntarily each year (on their own volition or on the recommendation of a loved one, health provider, employer or other non-criminal justice source) fell from 65.1 percent in 1997 to 62.5 percent in 2007.³⁰

According to a 2007 Substance Abuse and Mental Health Services Administration (SAMHSA) study, treatment spending fell from 2.1 percent to 1.3 percent of all health spending between 1987 and 2003. During that time, private insurance payments for treatment declined by 24 percent, while public

spending on treatment increased 7.5 percent annually (more slowly than other health spending), likely to pay for treatment mandated by the criminal justice system.³¹

In addition to capacity limitations that lead to lengthy waiting lists, many people seeking treatment voluntarily (i.e., without a criminal justice mandate) face significant barriers. Federal government data find that 37 percent of people who want but do not receive treatment simply cannot afford it, while another 15 percent don't know how to access it.³² This suggests that people with more resources are better able to get treatment when they want it, while those with fewer resources have fewer treatment opportunities outside of the criminal justice system.

Stopgap Approaches to Systemic Problems

Drug courts have flourished at the expense of support services that are more accessible and that are more effective at improving health and reducing crime.³³ The focus on drug courts has distracted attention from the real, systemic issues that drive the scale and cost of incarceration for drug law violations³⁴ – primarily aggressive policing strategies and draconian sentencing laws.³⁵

Even if drug courts were dramatically expanded to scale to cover all people arrested for drug possession, between 500,000 and 1 million people would still be ejected from a drug court and sentenced conventionally every year.

For people with few resources, the criminal justice system has become a primary avenue to treatment programs. Nonetheless, many who enter the criminal justice system do not actually receive such services. People who are in prison and have a history of regular drug use are today less than *half as likely* to receive treatment while incarcerated as in 1991.³⁶ The criminal justice system may ultimately provide the least help to the people with the greatest need.

The country's more than 2,100 drug courts were estimated to have roughly 55,000 participants in 2008,³⁷ representing a tiny fraction of the more than 1.6 million people arrested on drug charges every year.³⁸ That is, there is one drug court for every 26 drug court participants – and, for every one drug court participant, there are 29 other people arrested for a drug law violation who are not in a drug court.

Although drug courts tend to describe their participants as “drug-involved,” this tends to obscure the reality that an overwhelming number of drug court participants wind up there for a drug law violation – often petty possession. Most drug courts continue to exclude even the lowest-level sellers and the vast majority of courts exclude people with any prior conviction or current charge for a violent offense (due partly to an ill-advised federal funding requirement).³⁹

With drug court completion rates ranging widely from 30 percent to 70 percent,⁴⁰ it is probably optimistic to assume that even 25,000 people will complete a drug court program each year.* The rest are deemed to have “failed.” Even if drug courts were dramatically expanded to scale to cover all people arrested for drug possession, between 500,000 and 1 million people would still be ejected from a drug court and sentenced conventionally every year.⁴¹ As this report discusses, however, drug courts should not focus their resources on those arrested for simple drug possession.

Absent policies to stem the flow of people into (and retention within) the criminal justice system for petty drug law violations, drug courts and other criminal justice-based treatment programs will not meaningfully reduce the imprisonment of people who use drugs.⁴²

* According to the Government Accountability Office (GAO), drug court completion rates are not directly comparable because “drug court programs have different program completion requirements, the rates were measured over varying time periods, and study designs can affect the completion measures.” There is thus no single average rate of completion.

Disparate Impacts on People of Color

Drug law enforcement practices and sentencing policies have had profound, disparate impacts on people and communities of color. By 2003, African Americans were arrested for drug law violations at a rate 238 percent higher than whites⁴³ and African Americans and Latinos comprised two-thirds of people incarcerated for drug law violations⁴⁴ – even though they use and sell drugs at rates comparable to whites.⁴⁵

Mass arrests and incarceration of people of color – largely due to drug law violations⁴⁶ – have hobbled families and communities by stigmatizing and removing substantial numbers of men and women. In the late 1990s, nearly one in three African-American men aged 20-29 were under criminal justice supervision,⁴⁷ while more than two out of five had been incarcerated – substantially more than had been incarcerated a decade earlier and orders of magnitudes higher than that for the general population.⁴⁸ Today, 1 in 15 African-American children and 1 in 42 Latino children have a parent in prison, compared to 1 in 111 white children.⁴⁹ In some areas, a large majority of African-American men – 55 percent in Chicago, for example⁵⁰ – are labeled felons for life, and, as a result, may be prevented from voting and accessing public housing, student loans and other public assistance.

Unfortunately, drug courts may actually exacerbate existing racial disparities in the criminal justice system. First, drug courts may increase the number of people of color brought into the criminal justice system. An increase in drug arrests (an effect called net-widening) has been documented following the



establishment of drug courts.⁵¹ Second, the number of people of color incarcerated may increase; net-widening brings in many people who do not meet narrow drug court eligibility criteria.⁵² Third, African Americans have been at least 30 percent more likely than whites to be expelled from drug court⁵³ due in part to a lack of culturally appropriate treatment programs,⁵⁴ few counselors of color in some programs⁵⁵ and socioeconomic disadvantages.⁵⁶ Finally, people who do not complete drug court are often given a sentence that is significantly longer – in one drug court, even two to five times longer – than if they were conventionally sentenced in the first place (often, because they have forfeited the opportunity to plead to a lesser charge).⁵⁷

Understanding Drug Courts: What the Research Shows

Drug courts are some of the most-studied criminal justice programs in recent years. Unfortunately, most of the existing research suffers major methodological shortcomings that render oft-cited drug court data unreliable and misleading. Attempts to generalize the findings of numerous drug court evaluations – in studies called meta-analyses – have been hamstrung by the lack of credible data in the original research. Moreover, drug court evaluations, which are often conducted by program developers (rather than independent researchers), largely focus on identifying best practices and improving outcomes rather than fundamental policy questions, such as whether a particular drug court reduces crime, incarceration and costs and, if so, whether the drug court does so better than other policy options.

As one researcher testified at congressional hearing in 2010, “Over half of the criminal justice programs designated as ‘evidence-based’ programs in the National Registry of Evidence Based Programs include the program developer as evaluator. The consequence is that we continue to spend large sums of money on ineffective programs (programs that do no good, and in certain circumstances actually do harm). It also means that many jurisdictions become complacent about searching for alternative programs that really do work.”⁵⁸

This appears to be true of drug courts. A close analysis of the most reliable research studies finds that on the whole drug courts, as currently devised, may provide little or no benefit over the wholly punitive system they intend to improve upon. Although many individuals will benefit from drug courts each year, many others will ultimately be worse off than if they had received health services outside the criminal justice system, had been left alone, or even been conventionally sentenced.

Finding: Drug Court Research Is Often Unreliable

Despite the large number of studies on drug courts, the poor quality of that research has led many to conclude that there is insufficient evidence to demonstrate that drug courts reduce crime and drug use. As John Roman, senior researcher at the Urban Institute, put it: “The central criticism is that they employ convenience samples or compare drug court participants with drug court failures, in effect stacking the deck to ensure that the study finds a positive effect of drug court.”⁵⁹ Meta-analyses (i.e., studies that aggregate and analyze data from multiple drug court evaluations) have been conducted in an attempt to provide more generalized and reliable data; however, meta-analyses’ output is ultimately limited by the quality of the data that went in.

A 2006 meta-analysis report oft-cited by drug court supporters as conclusive evidence that drug courts reduce recidivism, for example, warns that “The overall findings tentatively suggest that drug offenders participating in a drug court are less likely to reoffend than similar offenders sentenced to traditional correctional options. The equivocation of this conclusion stems from the generally weak methodological nature [of] the research in this area.”⁶⁰ Of the 38 studies included in the meta-analysis, only four used “random assignment to conditions” in order to protect against bias. A separate 2006 meta-analysis also frequently relied upon by drug court proponents as proof of drug courts’ efficacy found that the studies it depended on for its analysis had measured recidivism rates only for drug court participants who successfully completed the program – a group that accounted, on average, for only 50 percent of those who originally enrolled.⁶¹

The poor quality of the research has led federal Government Accountability Office (GAO) analysts and other researchers to conclude that the drug court research lacks critical insight into what happens to participants once they are expelled or graduate, and provides limited evidence as to whether drug courts change behavior and lessen recidivism and re-arrest.⁶²

In an attempt to produce more reliable findings on drug court outcomes, the National Institute of Justice funded a five-year, national drug court study – the Multi-Site Adult Drug Court Evaluation (MADCE) – that aims to address many of the shortcomings of existing drug court research. Preliminary results of MADCE, which appears to be better designed than previous studies, were released in 2009 and 2010, and are considered in this report.

Although many individuals will benefit from drug courts each year, many others will ultimately be worse off than if they had received health services outside the criminal justice system, had been left alone, or even been conventionally sentenced.

**Finding:
Drug Court Outcomes Are Not
Markedly Better Than Probation**

Unsound drug court studies have repeatedly claimed that drug courts reduce drug use and criminal behavior, but significant methodological shortcomings call their positive findings into question. Indeed, preliminary results of the lengthiest and largest study so far, the MADCE, find that drug court participation did not lead to a statistically significant reduction in re-arrests.⁶³

Drug court evaluations that have reached more positive conclusions than the MADCE study have, in most cases, failed to account for the practice of “cherry-picking,” tend to use improper comparison groups, and frequently fail to include follow-up data. Ultimately, most drug court studies are so poorly designed that they reveal only the obvious: that the successes succeed and the failures fail.⁶⁴

Cherry-picking is the selection of people deemed more likely to succeed. Many drug courts cherry-pick participants for at least two reasons. First, prosecutors and judges may cherry-pick defendants because of the limited capacity of the drug court combined with the political importance of achieving high success rates. Second, some drug courts may opt to knowingly enroll persons who do not need treatment, but for whom drug court participation is seen as the only way to avoid a criminal record for a petty drug law violation. This may not be an insignificant occurrence. As mentioned previously, about one-third of drug court participants do not have a clinically significant substance use disorder.⁶⁵

As a result of cherry-picking, people who suffer from more serious drug problems are often denied access to drug court.⁶⁶ This, in turn, gives rise to misleading data because it yields drug court participants who are, on the whole, more likely to succeed than a comparison group of conventionally sentenced people who meet drug court eligibility criteria but who are not accepted into the drug court.

The use of non-equivalent treatment and comparison groups may be the most prevalent and serious flaw in drug court research. For example, many studies use a treatment group comprised either of graduates only or of graduates and those still in drug court, electing not to count the many who have dropped out or been ejected from the program. That treatment group is then compared with either a group that was

ineligible for drug court, that was eligible but opted for conventional sentencing, or that was expelled from or dropped out of drug court.⁶⁷ Although these biases can be mitigated to some extent by statistically accounting for people’s background and risk factors, including motivation and drug use severity, most drug court evaluations do not account for these biases.⁶⁸

A 2005 Government Accountability Office (GAO) analysis of drug court research attempted to extract conclusions based on studies that met *very basic* reliability standards. The GAO’s review found some positive drug court impacts on recidivism while participants remained in the program (in comparison with conventional sentencing), limited evidence that reductions in recidivism endure after program participation, and no evidence that specific drug court components (including incarceration sanctions) affect recidivism or program completion. The GAO concluded that drug courts’ impacts on drug use are mixed.⁶⁹

Three U.S. drug court program evaluations have used more reliable, controlled designs: Maryland’s Baltimore Drug Court, Arizona’s Maricopa County Drug Court and New Mexico’s Las Cruces DWI Court. These three programs randomly assigned people either to drug court or conventional probation. The studies of these three programs are the most rigorous drug court evaluations available. Importantly, even these studies fall far short of establishing the efficacy of drug courts under controlled conditions. Nor do they come close to illustrating that drug courts are typically effective in practice.

For example, Baltimore’s drug court participants were less likely to be re-arrested than the control group of probationers during the first two years after the initial arrest.⁷⁰ After three years, however, this difference became statistically insignificant, with a stunning 78 percent of drug court participants being re-arrested.⁷¹ Overall, drug court participants averaged 2.3 re-arrests, compared with 3.4 for the control group⁷² – a difference that is statistically significant but which may not warrant the substantial resources invested.

Maricopa County’s drug court did not reduce recidivism or drug use after 12 months.⁷³ A 36-month follow up study (which unfortunately excluded nearly 20 percent of original study participants) found that, although Maricopa County drug court participants were less likely to be re-arrested than the control group, there was no difference in the average number of re-arrests between the groups – probably because a portion of drug court participants had a higher number of re-arrests.⁷⁴



Las Cruces' DWI court found no difference in traffic offense reconviction rates, although DWI court participants' reconviction rates for alcohol-related or serious offenses (including simple and aggravated DWI) were slightly lower than for probationers.⁷⁵ Researchers cautioned that their sample sizes were small, and that enhanced DWI sanctions implemented in the state prior to the study may have “yielded the same or very similar results as a very expensive individual and group treatment program.”⁷⁶

Because virtually no drug court collects or maintains good data, it is unknown whether the Baltimore, Maricopa County and Las Cruces findings are representative. But what is certain is that any reliable data for one court cannot be assumed to apply to another (even if they admit similar types of people) because drug courts differ widely with respect to a host of relevant factors – including their use of drug testing, sanctions, incentives, hearings, treatment and social services, and judicial demeanor and experience.⁷⁷

Ultimately, the most sound studies, including preliminary findings from MADCE, suggest that despite a cosmetically more health-centered approach most drug courts produce remarkably similar outcomes to the conventional, wholly punitive approach that such courts seek to improve upon.

Finding: Incarceration Sanctions Do Not Improve Outcomes

To manage drug court participant compliance, the National Association of Drug Court Professionals (NADCP) encourages the use of rewards and sanctions, including incarceration and program expulsion.⁷⁸ Rewards might include praise from the bench, reduced frequency of drug testing, reduced fees or gift certificates. Sanctions, which grow more severe (or “graduated”) with subsequent transgressions – including continued drug use or drug relapse – might include warnings from the bench, increased frequency of drug testing, increased fees and incarceration in jail for days or weeks.

Research on the impact of “graduated sanctions” on compliance suffers from many of the same problems as drug court studies in general: a lack of data, site-specific findings that cannot be generalized to other courts, and selection bias, where drug court participants may be more likely to comply with court directives than those not accepted into the drug court.⁷⁹ Moreover, research has failed to tackle critical questions about sanctioning practices, including whether *incarceration* sanctions in particular (i.e., jail time) add value over a graduated sanctions framework that does not include incarceration. (The multi-year, multi-site MADCE study also does not address incarceration sanctions separately from other sanctions.)

As the California Society of Addiction Medicine has noted, not a single study has shown that incarceration sanctions improve substance use treatment outcomes.⁸⁰ Research also suggests no benefit in reduced re-arrests. According to one major study from the Washington State Institute for Public Policy, for example, adult drug courts reported a reduction in recidivism of 8.7 percent – significantly less than reductions recorded in probation-supervised treatment programs (18 percent) and on par with the reduction recorded by programs offering community-based drug treatment (8.3 percent), neither of which use incarceration as a sanction.⁸¹

California's experience, too, calls these sanctions into question. Since 2001, that state's landmark probation-supervised treatment program, which does not allow incarceration sanctions, has produced completion rates similar to those of drug courts (See Sidebar: Proposition 36, page 17).

Understanding Drug Courts: What the Research Shows

continued

Despite this lack of evidence, the power of drug court judges to order the incarceration of people who do not abstain from drug use or who commit minor program violations (including missing a meeting or being obstinate) is thought by many drug court proponents to be a critical component of drug court success. Incarceration sanctions are standard in drug courts and are even recommended by the NADCP.⁸² In at least some jurisdictions, incarceration is the single most widely utilized sanction despite the range of sanctions available to judges.⁸³ Each court determines its own policies for who is incarcerated, for what reason, and for how long. For drug court participants, this sanction can be severe.

Incarceration sanctions have been associated with a higher likelihood of re-arrest and a lower probability of program completion.⁸⁴ A person's sense of autonomy and motivation – integral to progress in treatment – can be undermined if they feel they are sanctioned unfairly.⁸⁵ Moreover, for days or weeks at a time, an incarceration sanction places a person who may be struggling with drugs into a stressful, violent and humiliating environment, where drugs are often available (and clean syringes almost never), where sexual violence is common (and condoms rare), where HIV, hepatitis C, tuberculosis and other communicable diseases are prevalent, where medical care is often substandard, and where drug treatment is largely nonexistent.

In drug court, incarceration for a drug relapse or a positive drug test often interrupts the treatment process, disrupts a person's attempts to maintain employment and stable social bonds, and reinforces the notion that the person is deviant. The pain, deprivation and atypical, dehumanizing routines that people experience while incarcerated can create long-term negative consequences.⁸⁶

As noted by the National Association of Counties, people with mental illness – at least one in six of the prison population⁸⁷ – are severely traumatized by incarceration.⁸⁸ Although only 30 percent of drug courts knowingly accept people with co-occurring mental health and substance use disorders,⁸⁹ the imposition of incarceration sanctions on these – and on undiagnosed – individuals is counterproductive and creates lasting harm.

Incarceration, when used to punish continued drug use or relapse, is fundamentally at odds with a health approach to drug use. In a treatment setting, relapse is met with more intensive services. In drug court, relapse is often met with temporary or permanent removal of treatment services.

Finding: Drug Courts Limit Access to Proven Treatments

Drug courts agree to provide participants with the services they need to address their drug issues in exchange for compliance with the court's conditions.⁹⁰ However, drug courts often fail to live up to their end of the bargain.

Drug courts often inadequately assess people's needs and, as a result, place them in inappropriate treatment. Overcrowded court dockets leave judges unable to effectively manage participant cases.⁹¹ Insufficiently trained court staff often send participants to services irrespective of their specific needs.⁹² Some courts use a "shotgun" approach in which they subject participants to several programs with incompatible philosophies.⁹³ In many cases, referrals to treatment are made not because the program is appropriate for the participant but because a drug court-approved treatment provider has an opening.⁹⁴

Moreover, abstinence-only ideology continues to obstruct appropriate treatment placement, particularly with respect to opioid addiction. According to the National Academy of Sciences' Institute of Medicine, "methadone maintenance has been the most rigorously studied [treatment] modality and has yielded the most incontrovertibly positive results."⁹⁵ Methadone and other opioid-maintenance treatments effectively prevent withdrawal symptoms, decrease cravings and overdose, and allow patients to maintain employment.⁹⁶ Maintenance treatments are well-documented to reduce crime and disease⁹⁷ while saving between \$4⁹⁸ and \$37⁹⁹ per dollar invested.

Despite endorsements by Centers for Disease Control and Prevention, the Institute of Medicine, SAMHSA, the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, the World Health Organization, and even the National Association of Drug Court Professionals,

In a treatment setting, relapse is met with more intensive services. In drug court, relapse is often met with temporary or permanent removal of treatment services.

many, and perhaps most, drug courts continue to prohibit methadone treatment or other maintenance therapies because of an ideological preference for abstinence.¹⁰⁰ This denial of a highly successful treatment for opioid dependence nearly guarantees that most opioid-dependent individuals will fail in drug court.

To be sure, some treatment quality issues are not unique to drug courts but are endemic to the larger publicly funded treatment system.¹⁰¹ The lack of diverse, high-quality treatment options is particularly detrimental for people of color, women and young people. Programs are predominantly staffed by counselors who lack the training, skills and experience to treat the diverse populations they encounter.¹⁰² African-American men and women with heroin or cocaine problems, for example, are asked to succeed in programs that were originally designed for white men struggling with alcohol problems.¹⁰³

As a National Institute of Justice report concludes, some drug court treatment session attendance problems may not be caused by intractable participants, but rather by the placement of participants in inappropriate or low-quality programs.¹⁰⁴ People who are harmed more than helped by a treatment program – or treated in a manner insensitive to their race, socioeconomic status, gender, sexuality or, ironically, the severity of their drug problem – are left without recourse and ultimately punished by a system that short-changes them. In the end, struggling drug court participants are often blamed for the inadequacies of the treatment system.

Finding: Drug Courts May Not Improve Public Safety

The claim that drug courts intend to reduce crime among “drug-involved offenders” is misleading. As previously mentioned, many drug court participants are not guilty of a crime against person or property but of a petty drug law violation – many of them apparently involving marijuana. Few drug court participants have long or varied histories of offending. Moreover, as previously noted, roughly one-third of drug court participants do not have clinically significant substance use disorders.¹⁰⁵ That is, the “criminal conduct” that drug courts are currently positioned to address is drug use, a behavior that for many participants is not compulsive.

Even when it comes to drug law violations, the majority of drug courts exclude all but those convicted of low-level drug possession. Even addicted persons who are caught selling petty amounts of drugs simply to support their own addictions are typically barred from drug court. As a result, most drug courts cater to those who are least likely to be jailed or imprisoned and who generally pose little threat to the safety of person or property. Only a handful of drug courts nationwide admit individuals with any previous serious or violent conviction, no matter how long ago the conviction occurred.¹⁰⁶

Moreover, when drug court participants are arrested, it is typically for a drug law violation, not for a crime against person or property. Early findings of the Multi-Site Adult Drug Court Evaluation (MADCE), for example, show that arrests for “violent, weapons-related or public order offenses” were “rare” for both the drug court participants and those in the comparison group.¹⁰⁷

As long as drug courts focus on people who use drugs (rather than on people who commit serious or violent crime), the programs are unlikely to provide worthwhile benefit over other policy approaches to drug use. Indeed, research consistently supports changing the population of drug court participants, because “drug courts work better for those who are at an inherently higher risk for future criminal behavior.”¹⁰⁸ Given who they accept, it is no surprise that drug courts on the whole have not produced significant reductions in serious or violent crime.

**Finding:
Drug Courts May Not Reduce Incarceration**

While drug courts do often reduce pre-trial detention, the extent to which they reduce incarceration overall is questionable. This conclusion is supported by the preliminary results of the five-year Multi-Site Adult Drug Court Evaluation (MADCE), which found no statistically significant reduction in incarceration for drug court participants over the comparison group after 18 months.¹⁰⁹ Several factors contribute to these apparently counter-intuitive findings.

First, drug courts may actually increase the number of people incarcerated for drug law violations due to net-widening, a process by which the introduction or expansion of a drug court (or other diversion program) is followed by an increase in drug arrests.¹¹⁰ Many of these newly arrested people will face incarceration rather than drug court because of drug court capacity constraints and strict eligibility criteria.

This phenomenon has been dramatic in Denver, where the number of people imprisoned for drug law violations doubled soon after the city established drug courts.¹¹¹ Net-widening may happen because law enforcement and other criminal justice practitioners believe people will finally “get help” within the system. Unfortunately, as in the Denver example, the number of people arrested for eligible offenses prior to the establishment of the drug courts had already far exceeded what the drug court could absorb.¹¹²

Second, people who do not complete drug court may actually face longer sentences – up to two to five times longer, according to one study – than if they had been conventionally sentenced in the first place.¹¹³ Since somewhere between 30 and 70 percent of all drug court participants will complete the program,¹¹⁴ the number of people ejected and facing potentially longer jail or prison sentences as a result of having participated in a drug court (partly for having forfeited their opportunity to plead to a lesser charge) is substantial.

Third, drug courts’ use of incarceration sanctions results in a significant total number of days spent behind bars.¹¹⁵ Indeed, data from a Baltimore drug court suggested that participants were incarcerated *more often* and for the *same amount of total days* as a control group of probationers, generally for program violations, not even including the incarceration later experienced by the 45 percent of people expelled from the program.¹¹⁶

Drug courts, as currently constituted, may ultimately serve not as an alternative but as an *adjunct* to incarceration.¹¹⁷

Drug Courts As Adjunct – Not Alternative – to Incarceration

Three years into a study of Baltimore’s drug court, 31 percent of participants had graduated after spending an average of nearly 22 months in the program. Another 11 percent were still participating, while 45 percent had been terminated after an average of almost 17 months in the program.¹¹⁸ In other words, nearly half of participants were deemed “failures” even though they had attempted to adhere to rigorous drug court requirements for nearly a year and a half – a period longer than what their conventional sentences may have been.

In a community-based program, improvements made during those 17 months could very well have been indicators of success, meriting further supports to maintain participants’ progress. In the drug court, however, 17 months of attempted adherence was eventually deemed insufficient, at which point the participants were removed from the program to begin serving day one of their original sentence.

Additionally, Baltimore’s misdemeanor drug court participants spent more than twice as many days incarcerated as their misdemeanor control counterparts and almost as many days as felony drug court participants.¹¹⁹ The drug court thus punished participants with misdemeanor charges as if they had been convicted of a felony.



**Finding:
Drug Courts May Not Cut Costs**

Claims that drug courts save many thousands of dollars per participant, or millions of dollars annually per drug court, are misleading. Not a single cost analysis has looked at the full range of costs of a U.S. drug court. Moreover, preliminary results from MADCE show that the average net cost benefit to society is not statistically significant.¹²⁰

Most studies calculate drug court savings based on assumed reductions in pre-trial detention and recidivism.¹²¹ However, as illustrated above, it is unclear to what extent, if at all, drug courts actually reduce incarceration.¹²² Even if drug courts do create some savings in pre-trial detention and recidivism, those savings are likely to disappear when program costs are accounted for – costs that are almost always overlooked. Such costs include drug tests, the not uncommon use of incarceration for detoxification,¹²³ net-widening,¹²⁴ incarceration sanctions,¹²⁵ and the cost of harsher sentences on expelled drug court participants.¹²⁶

Additionally, drug court cost-savings assertions are often inflated by inaccurately assuming that all drug court participants are bound for jail or prison. Because most drug courts exclude people with more serious offenses or histories,¹²⁷ it is inappropriate to compare the cost of a one-to-three year drug

court program against the cost of a one-to-three year period of incarceration. Given who is actually in most drug courts, the cost of drug court is more accurately compared with a jail term of a few weeks or months followed by one-to-three years of probation – an issue overlooked in nearly every drug court cost analysis.¹²⁸

Finally, it must also be asked whether drug courts save money not only in comparison with conventional sentencing of those who possess small amounts of drugs, but also in comparison with a non-criminal justice approach. Such a comparison would uncover significantly different outcomes, costs and savings for an entirely different set of investments. For example, drug treatment has consistently been associated with net benefits and savings, ranging from \$1.33 to \$23.33 saved per dollar invested.¹²⁹

Although some may suggest that drug courts reduce “society costs” by reducing criminal behavior, this – even if true – is hardly unique to drug courts. Drug treatment itself is associated with significant reductions in illegal activity, particularly reduced drug use and reduced drug sales, as well as minor property offenses associated with drug-procurement behavior.¹³⁰ According to one recent analysis by the Washington State Institute for Public Policy, drug courts produced \$2 in benefits for every dollar spent. By contrast, drug treatment in the community produced \$21 in benefits to victims and taxpayers in terms of reduced crime for every dollar spent – or ten times the benefit produced by drug courts.¹³¹

Mixing Treatment and Punishment: A Faulty Approach

The fundamental tension that exists between the goals of treatment and punishment – and the predominance of punishment over treatment in any criminal justice-based program – means that drug courts cannot hope to substantially reduce the number of people incarcerated for drug use as long as drug use is criminalized. Indeed, it means that drug courts are apt to incarcerate those who could most benefit from treatment.

Fundamental Paradox of Drug Courts

Drug courts are grounded in two contradictory models. The disease model assumes that people with an addiction disorder use drugs compulsively – that is, despite negative consequences.¹³² The rational actor model, which underlies principles of punishment, assumes that people weigh the benefits of their actions against the potential consequences of those actions.¹³³

These dueling models result in people being “treated” through a medical lens while the symptoms of their condition – chiefly, the inability to maintain abstinence – are addressed through a penal one. The person admitted into drug court is regarded as not fully rational and only partially responsible for their drug use; yet the same person is considered sufficiently rational and responsible to respond to the “carrots and sticks” (i.e., rewards and sanctions) of drug court.¹³⁴

Under this approach, those suffering more serious drug problems are most likely to “fail” drug court and be punished.¹³⁵ In the end, the person who has the greatest ability to control his or her own drug use will be much more likely to complete treatment and be deemed a “success.”

In blending two incompatible philosophies,¹³⁶ a drug court (or any other criminal justice-based program) cannot adhere to both approaches and faithfully embody either one. This incongruity results in thousands of drug court participants being punished or dropped from programs each year for failing to overcome addictions in a setting not conducive to their success.

Abstinence-Only and the Predominance of Punishment Over Treatment

A health-centered response to drug use assesses improvement by many measures – not simply by people’s drug use levels, but also by their personal health, employment status, social relationships and general wellbeing. “Success” in the criminal justice context, by contrast, boils down to the single measure of abstinence – because any drug use is deemed illegal behavior. Both approaches already exist in the U.S. today; the wealthy often benefit from one, while people of less means are by and large subject to the other.

Rehabilitative regimes that rely on criminal justice coercion have historically devolved into increasingly punitive systems.¹³⁷ Drug courts’ attempts to meld treatment and punishment ultimately succumb to the dominance of punishment over therapeutic principles. Though a judge may provide leniency to those who make important strides, drug court participants will eventually be labeled “failures” and sanctioned unless they achieve and maintain abstinence for a period of time that the judge deems reasonable. Duty-bound to penal codes that criminalize drug use, drug courts’ ultimate demand is complete abstinence from drugs. Meanwhile, the many other medical and social indicators of wellbeing become secondary or tertiary.

No form of treatment – court-mandated or otherwise – can guarantee long-term abstinence from drug use. Moreover, lapses in treatment compliance are a predictable feature of substance use disorders, just as they are with other chronic conditions, including diabetes and hypertension. But drug courts make it difficult for people whose only “crime” is their drug use to extricate themselves from the criminal justice system. The court, bound to the benchmark of abstinence, and rooted in principles of deterrence, retribution and incapacitation,¹³⁸ equates drug relapse with criminal recidivism and punishes it as such.

Drug court adaptations in Canada, Australia and the United Kingdom have expanded measures of success to include decreased drug use and crime, while broadly allowing opioid-maintenance therapy (such as methadone) and, in some circumstances, tolerating cannabis use.¹³⁹ In the U.S., too, a handful of drug courts have adopted similar harm reduction measures, suggesting that some pragmatic reforms are feasible even absent a major shift in domestic drug policies.

Proposition 36: Better But Not Health-Centered

California provides an important case study in how treatment within the criminal justice system will always come second to that system's primary missions of deterrence, retribution and incapacitation.

Passed by 61 percent of voters in 2000, Proposition 36 permanently changed the state's sentencing law to require probation and treatment rather than incarceration for a first and second low-level drug law violation. The Drug Policy Alliance, with support from many others, designed Prop. 36 and spearheaded the campaign to pass the law. Its intent is to provide universal access to treatment for eligible candidates while prohibiting their incarceration (including incarceration sanctions), to prevent cherry-picking of participants, to allow drug testing for treatment (but not punitive) purposes, and to empower health providers – not judges – to make treatment decisions.¹⁴⁰



Prop. 36 represents a positive modification of drug courts, taken to scale. From 2001-2006, when Prop. 36 was funded at \$120 million a year, 36,000 people were enrolled annually¹⁴¹ (nearly ten times the number of people enrolled in all of California's drug courts and nearly two-thirds the number of people participating in all drug courts nationwide),¹⁴² completion rates were comparable to those of other criminal justice programs,¹⁴³ and the number of people in California prisons for drug possession dropped by more than 27 percent.¹⁴⁴ An estimated \$2,861 was saved per participant, or \$2.50 for every dollar invested,¹⁴⁵ and there were no adverse effects on crime trends.¹⁴⁶

Prop. 36 is instructive in that its participants' completion rates are comparable to drug courts', but Prop. 36 participants were not cherry-picked and were not subject to incarceration sanctions.¹⁴⁷

Nevertheless, Prop. 36 remains – like drug courts – squarely within the criminal justice system.

Admission to the program follows conviction (similar to most drug courts), participants appear to have displaced voluntary clients in cash-strapped publicly funded programs (even though Prop. 36 funding helped establish nearly 700 new program sites),¹⁴⁸ and failure to maintain abstinence ultimately results in expulsion from the program and imposition of conventional sentencing.¹⁴⁹

Despite Prop. 36's demonstrated cost savings and public safety record, funding decisions ten years later confirm that treatment in California remains secondary to punishment. Over a four-year period, California entirely eliminated treatment funding for Prop. 36 – from a high of \$145 million in 2007-08 to nothing in 2010-11.

Toward a Health-Centered Approach to Drug Use

Twenty years of evidence clearly demonstrates that drug courts cannot effectively reduce the burden on the criminal justice system created by 1.6 million annual drug arrests and that they cannot provide health-oriented treatment within a punitive structure. Indeed, it appears that, on a policy level, they may be making matters worse by absorbing resources and momentum that could be focused on developing non-criminal justice responses to drug use and by preserving criminal justice resources for addressing crimes against people and property.

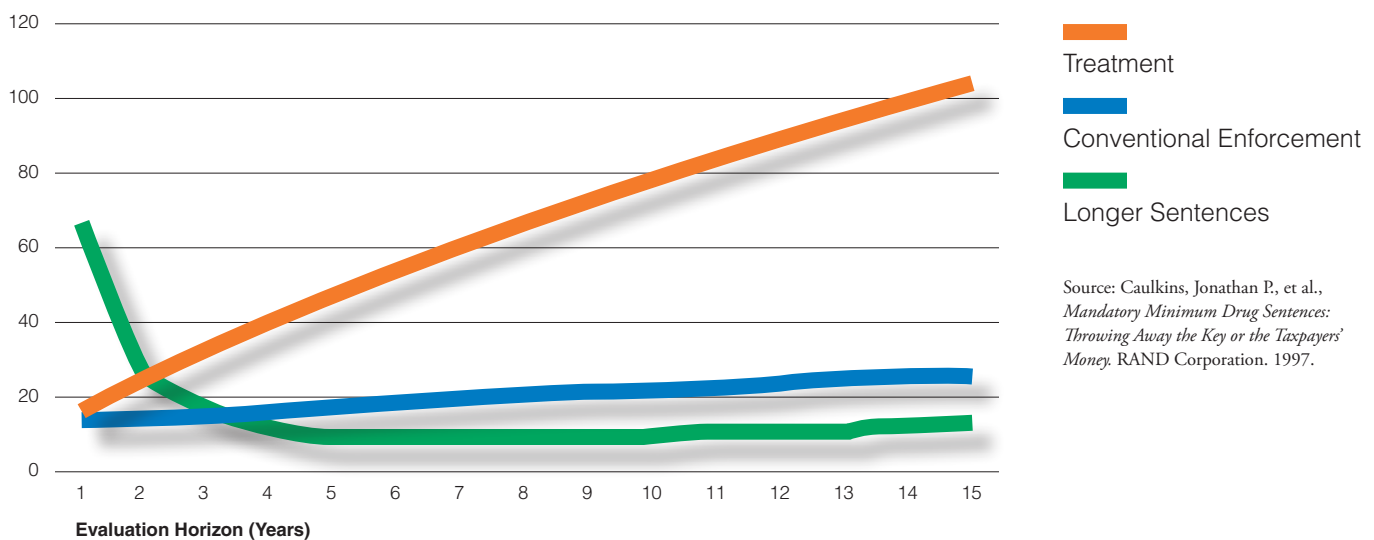
Stopgap measures to address the drug arrest epidemic within the criminal justice system have failed. It is time for a new approach to drug use – one focused on health. A health paradigm recognizes that the criminalization of drug use does more harm than good; that prevention, treatment and other social supports are often more appropriate and cost-effective than criminal justice involvement; and that, similar to alcohol consumption, drug use does not always impede a person’s functioning or ability to be successful, and therefore not everyone who uses a drug needs treatment.

Moving from the criminal paradigm to this new health paradigm entails improving and standardizing drug court practices, working toward the removal of criminal penalties for drug use, and shifting investments into public health programs that include harm reduction and other interventions and treatments.

Recommendation: Reserve Drug Courts for Serious Offenses and Improve Practices

As this report emphasizes, drug courts are bound by the rules of the criminal justice system in which they exist. As policy makers and advocates work to improve that larger system, however, there are things that drug courts themselves – and those who dispense drug court funding – can do immediately to improve and standardize practices to more effectively and cost-effectively apply their limited resources.

Kilograms of Cocaine Consumption Prevented per Million 1992 Dollars Spent



Numerous scholars and researchers who have looked closely at drug courts have proposed a series of reforms and best practices to improve drug courts, including:

- Focus drug court resources on people facing lengthy prison terms to ensure that drug court is actually a diversion from incarceration and not more restrictive than the conventional sentence;¹⁵⁰
- Adopt objective admission criteria and reduce the prosecutor's role as gate-keeper;¹⁵¹
- Use a pre-plea rather than a post-plea model;¹⁵²
- Ensure due process protections and enhance the role of defense counsel;¹⁵³ and
- Improve data collection, research rigor, and implementation of demonstrated best practices.¹⁵⁴

To this list, the Drug Policy Alliance recommends adding the following:

- Prohibit the use of incarceration sanctions for drug law violations and provide a treatment response instead;
- Incorporate health measures – not simply abstinence – into program goals;
- Improve overall treatment quality and employ opioid maintenance treatments and other evidence-based therapies;
- Work to ensure that drug courts are more health-oriented than punitive;
- Use drug tests as a treatment tool, not as punishment;
- Empower treatment professionals in decision-making;
- Reduce turnover of trained and experienced court, probation and treatment staff to improve program continuity and consistency;
- Ensure that punishment for “failing” the program is not worse than the original penalty for the offense; and
- Work to establish other local alternatives outside the drug court for those who want and need access to treatment but do not warrant intensive court resources (e.g., probation-supervised treatment).

While these short-term fixes would help improve the functioning, transparency and accountability of drug courts, policymakers must also ask what other interventions might be equally or more successful with different populations. After all, there will not be one policy solution to the issues of drug use or public safety. Rather, U.S. drug policy will benefit when a range of options is available and when robust research drives policy decisions.

Recommendation: Work Toward Removing Criminal Penalties for Drug Use

Even as drug courts continue to proliferate, the federal government and some states are seeking out more systemic changes to address the dual burdens of mass drug arrests and incarceration. Many of these measures aim to reduce the number of people going to prison for a petty drug offense, shorten the length of time served for drug law violations, or reduce probation and parole revocations for drug use.¹⁵⁵

To limit the number of people going to prison for a petty drug law violation, several states have implemented alternative-to-incarceration programs and others are moving in that direction. Several years ago, for example, Texas successfully opted for alternatives to incarceration rather than build a new prison.¹⁵⁶ New York adopted major reforms of its 36-year-old Rockefeller Drug Laws in 2009, including alternatives to incarceration for petty drug possession and sales offenses.¹⁵⁷ As this report was published, California was considering ending prison sentences for most petty drug offenses. South Carolina was aiming to reduce its prison population by handling more low-level drug and other offenses outside of prison walls.¹⁵⁸ And an Oklahoma legislator had promised to introduce his own plan to divert thousands of people convicted of petty offenses from prison.¹⁵⁹

Programs that provide alternatives to incarceration for a substantial portion of people convicted of a petty drug law violation improve the utilization of limited resources and allow the criminal justice system to focus on matters of greater public safety. As some states are already learning, reducing penalties is an even more effective way to reduce costs while preserving public safety. In 2010, Colorado reduced penalties for some low-level possession offenses and New Jersey restored judges' discretion to waive mandatory minimum sentences for certain low-level drug law violations that take place in “drug-free zones.” In late 2010, Indiana's Criminal Code Evaluation Commission advised the state to shorten sentences for drug possession and some low-level sales offenses.¹⁶⁰ And at the federal level, landmark legislation in 2010 dramatically reduced disproportionate sentencing for crack cocaine, and repealed a mandatory minimum drug sentence for the first time since the 1970s (what had been a five-year sentence for possession of five grams of crack cocaine – the weight of two sugar packets).¹⁶¹

As some states are already learning, reducing penalties is an even more effective way to reduce costs while preserving public safety.

These are all important steps toward reducing the incarceration of people for drug use. But they do not reduce (and may run the risk of increasing through net-widening) the number of *drug arrests* that absorb huge amounts of law enforcement and court personnel time and overwhelm alternative-to-incarceration programs. As a result, some states and local authorities are pursuing programs aimed at reducing drug arrests.

At the state level, spending can be reprioritized in order to focus resources on preventing people from entering the criminal justice system – and hastening their exit from it. In 2009, for example, California spent \$90 million in federal Byrne Justice Assistance Grants on drug treatment and intensive probation supervision instead of on the state’s “buy-bust” programs that result in thousands of low-level drug arrests annually.¹⁶² In so doing, the state generated about \$200 million in cost savings rather than the additional costs (of as much as \$900 million) that would have been associated with new court cases and incarceration.¹⁶³

At the local level, too, resource allocation is being rethought and some jurisdictions are working to implement changes in arrest practices. For example, a collaborative effort in Seattle, which includes law enforcement, defense attorneys and social services among others, expects to roll out in 2011 a pre-arrest diversion program called Law Enforcement Assisted Diversion (LEAD) that aims to reduce the number of people entering the criminal justice system for a low-level drug law violation by providing linkages to community-based treatment and support services.¹⁶⁴ In San Diego, the police department has calculated significant cost savings to the local government through its Serial Inebriate Program (SIP), which provides treatment and housing to the city’s most costly individuals suffering from alcoholism and chronic homelessness.¹⁶⁵

These changes are steps in the right direction. However, they fall short of what is ultimately necessary to reduce the role of the criminal justice system in this health issue: a removal of criminal penalties for drug use absent harm – or substantial risk of harm, such as driving under the influence – to others. As long as more than 1.6 million people are arrested every year for drug law violations and hundreds of thousands more are sanctioned for drug-related violations of parole or probation,¹⁶⁶ drug cases will continue to swamp the criminal justice system and have a negative impact on individuals and communities.

Nationally, 46 percent of all drug arrests are for marijuana possession.¹⁶⁷ Ending criminal penalties for marijuana use would represent a significant advancement toward a health approach. Lawmakers and voters in numerous states considered bills and ballot measures to eliminate or reduce penalties for marijuana possession in 2010 and many are expected to do so again in 2012. With recent polls showing nearly half the country in favor of taxing and regulating marijuana, there is currently unprecedented momentum for major policy reforms.

In recent years, other countries have taken even broader steps toward ending the criminalization of drug use. In 2008, a Brazilian appeals court ruled that based on the constitutional principles of harm, privacy and equality, the law criminalizing drug possession for personal use is unconstitutional. In 2009, Mexico, Argentina and the Czech Republic all made possession of small quantities of drugs non-criminal offenses. Though these reforms were made absent a larger health-centered agenda, they reflect an increasing awareness that prohibitionist policies are counterproductive – at least with respect to drug possession.

Portugal presents the most significant and successful example of a post-criminalization, health-centered drug policy. In 2001, Portuguese legislators decriminalized low-level drug possession and reclassified it as an administrative violation. At the heart of this policy change was the recognition that the criminalization of drug use was not justifiable and that it was actually a barrier to more effective responses to drug use.¹⁶⁸

Portugal's Post-Criminalization Policy Success

Portugal's move to decriminalize all low-level drug possession in 2001 was not simply a legal change but a comprehensive paradigm shift toward expanded access to prevention, treatment, harm reduction and social reintegration services.¹⁶⁹

The explicit aim of the policy shift was to adopt an approach to drugs based not on dogmatic moralism and prejudice but on science and evidence. The criminalization of drug use was deemed a barrier to more effective, health-centered responses and at odds with the principle that people who use drugs deserve to be treated with dignity and respect.¹⁷⁰

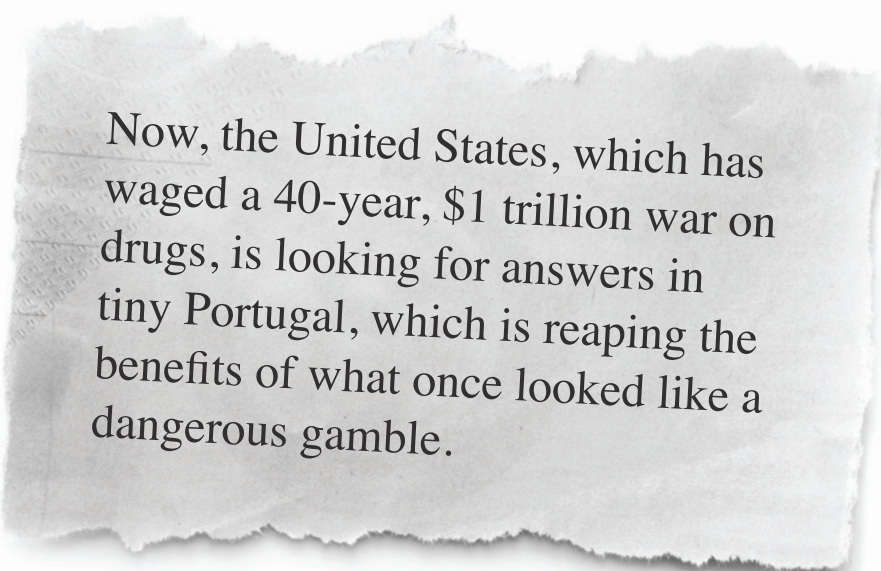
Portugal's legal and policy changes altered the role of police officers, who now issue citations – but do not arrest – people found in possession of small amounts of illicit substances. Cited persons are ordered to appear at a “dissuasion commission,” an administrative panel that operates outside of the

criminal justice system. The panel, with two health practitioners and one legal practitioner, examines the individual's needs and circumstances, and determines whether to make referrals to treatment or other services, and/or to impose fines or other non-criminal penalties.

By decreasing the stigma around drug use, decriminalization allowed for the discussion of previously taboo issues and optimum policy responses, including whether to create supervised injection facilities and to introduce sterile syringe exchange programs in prisons.¹⁷¹ Further, the administrative, community-based “dissuasion commissions” have provided earlier intervention for drug users, a broader range of responses, an increased emphasis on prevention for occasional users, and increased provision of treatment and harm reduction services.¹⁷²

AP Associated Press

December 27, 2010
*Portugal's drug policy pays off;
US eyes lessons*



Now, the United States, which has waged a 40-year, \$1 trillion war on drugs, is looking for answers in tiny Portugal, which is reaping the benefits of what once looked like a dangerous gamble.

A decade later, Portugal's paradigm change from a punitive approach to a health-centered one has proved enormously popular. It has not created a haven for "drug tourists" nor has it led to increased drug use rates, which continue to be among the lowest in the European Union.¹⁷³ Rather, fatal overdose from opiates has been cut nearly in half,¹⁷⁴ new HIV/AIDS infections in people who inject drugs fell by two-thirds,¹⁷⁵ the number of people in treatment increased¹⁷⁶ and the number of people on opioid maintenance treatments more than doubled.¹⁷⁷ Portugal's paradigm shift has facilitated better uptake of prevention, treatment, harm reduction and social reintegration services and, ultimately, a more realistic approach to drug use driven by experience and evidence.¹⁷⁸

The failure of U.S. stopgap measures and the success of the Portuguese model challenge advocates and policymakers in the U.S. to focus on building the political will to work toward removing criminal penalties for drug use and implement instead a comprehensive and effective health-centered approach.

**Recommendation:
Invest in Public Health, Including
Harm Reduction and Treatment**

Public health interventions are wise, necessary long-term investments. They reduce the harms associated with drug use, prevent crimes against people and property, and cut associated costs. These approaches must not begin and end with abstinence-only programs. While treatments aimed at supporting people who desire to cease drug use must be made much more widely available, strategies to prevent overdose deaths and reduce the spread of communicable disease are also critical and must be expanded.

A 2006 analysis found that every dollar invested in drug treatment saves \$7 due to increased employment earnings and reduced medical care, mental health services, social service supports, and crime.¹⁷⁹ A 1994 RAND study commissioned by the U.S. Army and the White House Office of National Drug Control Policy found treatment to be seven times more effective at reducing cocaine consumption than domestic law enforcement, ten times more effective than drug interdiction, and 23 times more effective than trying to eradicate drugs at their source.¹⁸⁰ A 1997 SAMHSA study found that treatment reduces drug selling by 78 percent, shoplifting by almost 82 percent, and assaults by 78 percent.¹⁸¹

Despite the health and fiscal benefits of drug treatment, too many people lack access to it. Federal health care legislation, signed by President Obama in 2010, takes a promising step forward by expanding eligibility for private and public insurance and by requiring all insurers to provide coverage for substance use and mental health service benefits on par with coverage for other chronic conditions. This parity requirement will help to reduce two significant barriers to treatment – cost and stigma – by promising to make treatment accessible through public and private health insurance and through more doctors' offices.

Significantly, under the new health care legislation, all nonelderly adults with income up to 133 percent of the federal poverty level will become eligible for Medicaid in 2014.¹⁸² This will capture many currently uninsured people, including many in the criminal justice system. Medicaid eligibility will not translate into real access to treatment, however, unless states work to preserve, and then expand, their addiction treatment systems. As adults become able to access drug treatment through Medicaid, it will make even less sense to invest in resource-intensive drug courts that focus on people whose illegal activity is largely limited to drug use. These new dollars, too, must not be devoted solely to abstinence-only approaches, such as those mandated by drug courts, but to a wide range of services that focus on improving people's health.

Bringing drug treatment into the primary care setting is essential, but it is not enough. Programs designed for people who do not routinely access the mainstream health care system are also needed. For example, syringe exchange programs and safe injection facilities – which focus on empowering individuals to make healthier choices – have proven to be safe, effective opportunities for more marginalized people to engage help and services.¹⁸³

Just as public health principles support the use of condoms, contraceptives, cigarette filters and seat belts to reduce health risks, drug policies must seek to reduce the harms and risks associated with drug use. As Portuguese policymakers learned, an overemphasis on abstinence can obstruct efforts to

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successfully mitigate drug-related harms.¹⁸⁴ Programs that focus on reducing drug-related harms and risks result in better individual and public health than criminal justice interventions – including drug courts – and, by any measure, deliver more bang for the buck. Failing to invest in such programs is expensive in terms of both lives and dollars.

Drug overdose is now the second leading cause of accidental death, trailing only motor vehicle fatalities.¹⁸⁵ According to the National Institute on Drug Abuse, injection drug use is responsible for one-third of adult and adolescent HIV/AIDS cases, while more than one-half of HIV/AIDS cases at birth are the result of a parent contracting HIV through injection drug use. Hepatitis B and C are prevalent in 65 percent and 75 percent, respectively, of people who have injected drugs for six years or less. People who use drugs, either intravenously or otherwise, are two to six times more likely than others to contract tuberculosis. The geographic distribution of syphilis and gonorrhea infections reflects the distribution of crack cocaine use.¹⁸⁶

Overdose deaths and the spread of HIV/AIDS, hepatitis, tuberculosis, syphilis and gonorrhea are *largely preventable*. Good Samaritan policies, which encourage people to call for help in the case of a suspected drug overdose, may help reduce fatalities. Proven public health measures, such as

syringe exchange programs, have consistently been shown to substantially reduce the rate of HIV/AIDS transmission among people who inject drugs without increasing injection drug use.¹⁸⁷ Facilities that allow supervised, on-site injection of drugs reduce vein damage, disease transmission¹⁸⁸ and fatal overdose¹⁸⁹ as well as public disorder, improper syringe disposal and public drug use.¹⁹⁰ Additionally, the provision of naloxone (an FDA-approved overdose antidote) to people who use opioids – either as prescription analgesics for pain (such as phentanyl, oxycodone, hydromorphone and methadone) or as a result of opioid dependence – can greatly reduce fatal overdose.¹⁹¹

Moreover, non-judgmental services such as syringe exchanges reach people turned off by or excluded from abstinence-only programs. In 2005, more than 85 percent of roughly 160 syringe exchange programs in the U.S. regularly made treatment referrals.¹⁹² Many referrals were for people who do not inject drugs, illustrating that such programs deliver important health services for a larger community beyond their primary syringe-exchanging clients.¹⁹³ In 2009, the federal government removed a significant hurdle when it ended the ban on federal dollars going to life-saving syringe exchange programs. Much more is needed in the way of direct investment – and these costs could easily be covered by reduced investment in arrests and incarceration for drug law violations.

Similarly, many people struggling with drugs may benefit from a variety of support services before – or in lieu of – formal treatment services. It is well-documented that stable social and financial circumstances help prevent relapse both during and after treatment, regardless of whether a person is mandated to treatment by the courts.¹⁹⁴ Efforts to aid people with drug problems might therefore involve addressing other needs entirely, such as access to physical and mental health services, housing, employment or education.

Conclusion

There are several reasons why now is the time to rethink our drug policies, including drug courts. The hysteria of the 1980s drug war is now a distant memory, and states and the federal government are seeking cost-effective ways to achieve better results. The Obama Administration's commitment to a greater public health approach than its predecessors has already resulted in significant policy reform, with the inclusion of drug treatment in the 2010 health care laws. At the same time, the federal crack cocaine sentencing reform of 2010 illustrates that bipartisan consensus is possible on drug policy. Moreover, the evidence from abroad regarding the health and fiscal benefits of harm reduction strategies and non-punitive approaches has grown dramatically. And here at home, harm reduction programs once regarded as inconceivable in some parts of the U.S. are now standard. Finally, the criminalization-focused approach to drug policy, including drug courts, continues to fail to demonstrate its efficacy or cost-efficacy.

Let's be clear: drug court programs have saved lives. People correctly perceive them as having benefits. Drug court proponents deserve to take pride in their accomplishments. However, we all, including drug court supporters, have an obligation to step outside the drug court paradigm to consider other approaches that might work better and whether the particular modalities of the drug court are best directed at people other than those whose only offense is drug use or drug possession. This will not be easy. People have a vested interest in defending and promoting that which they have given so many years of their lives. Drug courts have developed substantial political rapport, which risks providing them immunity from honest, critical analyses.

Looking forward, however, we should strive toward a world where drug courts focus primarily on more serious offenses and where drug use absent harm to others is no longer regarded as a criminal justice matter.



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About the Drug Policy Alliance

The Drug Policy Alliance (DPA) is the nation's leading organization promoting alternatives to the drug war that are grounded in science, compassion, health and human rights. DPA serves as a national watchdog and global advocate for sane and responsible drug policies. It is headquartered in New York and has offices in California, Colorado, New Jersey, New Mexico and Washington, D.C.

DPA has built broad coalitions to reduce the role of criminalization in drug policy at the state and federal levels. DPA spearheaded the passage and implementation of Proposition 36, California's landmark treatment-not-incarceration law, approved by 61 percent of California voters in November 2000. Prop. 36 allows people convicted of a first and second low-level drug law violation the opportunity to receive drug treatment instead of incarceration. Since the law's passage, more than 300,000 people have been diverted from conventional sentencing to drug treatment, saving taxpayers more than \$2.5 billion. For all the reasons outlined in this report, DPA remains committed not just to alternatives to incarceration but to ultimately removing criminal penalties for drug use absent harm to others and to expanding health-centered approaches to drug use.

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